



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**INFANT FEEDING PREFERENCE – HOMES**

Name of infant \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ will feed your infant breastmilk provided by you and / or we  
(name of provider)  
will provide iron fortified infant formula.

The formula we provide is: \_\_\_\_\_

Please mark your preference (choose all that apply)	Date _____ Birth – 3 months	Date _____ 4 – 7 months	Date _____ 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the home to breastfeed my infant.			
I want the home to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

This day care home is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the home must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Date _____ 4 – 7 months	Date _____ 8 – 11 months
I want the home to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid food for my infant when he / she is ready for it.		

First Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Second Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Third Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

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